1979(?)

Blue Cross of Northeast Ohio at 45

HOSPITAL SERVICE ASSN PAYS YOUR HOSPITAL BILLS

YOU PAY 75c A MONTH

A Special Annual Report

Blue Cross of Northeast Ohio at 45

where we've been . . .
where we are . . .
where we're headed . . .

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ABOUT OUR COVER

The striking poster by artist Joseph Binder was created in 1934, the same year Cleveland Hospital Service Association was born.
Visually as fresh today (but clearly outdated financially), the poster marks the first use of the blue cross to identify a hospital service plan.
The late E. A. Van Steenwyck, then head of the original St. Paul, Mn. Plan, was the creator.
Our thanks go to Blue Cross and Blue Shield of Minnesota for permission to reprint.

ABOUT OUR 50TH ANNIVERSARY SYMBOL

A golden celebration by Blue Cross Plans across the country to commemorate the beginnings of the Blue Cross concept.

Page 2 highlights the birth of a daring social movement.

LIVE LONG AND LIKE IT

Somehow it seems there has always been a "Blue Cross". And yet as we observe the 45th year of this Plan, we are aware that prepayment as we know it today is only 50 years old.

A large segment of the American population can recall when this peculiar but typically American phenomenon did not exist. But so pervasive, so effective has the Blue Cross movement been that it directly affects the lives of nearly one of every two Americans either through direct service in the private sector or through its myriad activities in developing cost effective programs for providers, and positive health strategies and better life style for consumers. Blue Cross Plans touch the lives of nearly every American.

What lies behind this remarkable growth from nothing to being an integral part of the health care system? How did the Blue Cross movement become in less than the span of one lifetime, a force so dominant, so accepted, that all of us young and old alike, accept it as being a natural, normal part of our very existence?

Answering the foregoing questions is part of the task of this annual report. In the following pages I believe you will sense the response to public need that characterizes Blue Cross Plan activities. I believe you will recognize the typically American solution to problems that the prepayment movement represents.

The spirit of volunteerism is an important key. The Board of Trustees of Blue Cross of Northeast Ohio are volunteers — unpaid for their services, but richly rewarded in the sense of accomplishment they can achieve in meeting community needs.

Nowhere else in the world can you find the unique blend of community interests and leadership that Blue Cross Plans represent. No one owns Blue Cross; it belongs to all the people. And so this report is dedicated to all of you, enrolled and unenrolled alike.

H. Stephen Madsen

Donald R. Riordan Sr.
President of
Blue Cross of
Northeast Ohio

H. Stephen Madsen
Chairman of the
Board of Trustees
Blue Cross of
Northeast Ohio

1958 — More than 20 years ago Blue Cross of Northeast Ohio was urging good health through sensible and healthy lifestyles. This ad was one in a series of the *Live Long and Like It* campaign.

Trying to report on the activities of Blue Cross of Northeast Ohio for just one year is not an easy task. Trying to capture and distill the flavor of 45 years of service is almost an impossible job.

Throughout this report you will find many of the standard statistical indicators of progress and achievement. On the inside back cover you will find a summary of our results for the year past. But as revealing as these facts and figures may or may not be, they do not truly capture the essential being of this Blue Cross Plan. Nor do figures alone summarize the growth and development of the Blue Cross movement.

Our anniversary report thus is a very complex story with many threads woven into it. Because the reality of any organization is in the sum of the perceptions people have about it, we have included the efforts of many authors. Some are new to the Blue Cross movement. Others are seasoned writers with long years of experience in health care and health care prepayment. And we have included examples of our advertising messages both for historical purposes and for their ability to give clues about us as a living, growing, contemporary organization.

But this report is of the past. Now we stand at the threshhold of a new decade. Challenges to us, to the health care system and to the whole nation, loom everywhere. But I am confident we can meet whatever tasks the future holds. My confidence springs from witnessing the leadership shown by those who nurtured the Plan to its present position. With their examples to guide us, the present staff of Blue Cross of Northeast Ohio — filled with that same sense of dedication and destiny — will continue to build and grow the better to serve the community. And that's our reason for being.

Donald R. Riordan, Sr.

1929-1979
Commemorating fifty years
Working for a healthier America

Blue Cross. Blue Shield.

A 50th Anniversary . . . . origins of a golden idea

Baylor University, Dallas, Texas, 1929. Where it all began.

Justin Ford Kimball, a Baylor University administrator and a pioneer in the prepayment concept.

Fifty years ago at the start of America's greatest depression, our nation witnessed a new social movement in paying hospital costs . . . the Blue Cross concept of voluntary prepayment care Plans.

Times were bleak, with unemployment rising and businesses, including hospitals, struggling against financial pressures.

In Dallas, Texas, during that black year of the crash in 1929, Justin Ford Kimball, a Baylor University administrator, formed a local hospital prepayment plan to help teachers pay for their health care bills.

Kimball's idea, known as the Baylor Plan, provided $6 a day for 21 days of hospital care. It cost teachers 50¢ a month to join this common pool. The teachers enthusiastically supported the Plan and soon other Dallas firms were enrolling their employees. By year's end, enrollment topped 2000.

The economics of this concept stimulated other hospitals coast to coast; hospital service associations — soon to be known as Blue Cross Plans (see p. 3) sprang up overnight to help the American public pay its hospital bills and thus give financial relief to near-bankrupt hospitals.

Hospital administrators were particularly supportive of the Baylor Plan's idea of prepaying for services rather than making cash payments for services rendered . . . in fact, service benefits rather than cash indemnities are still the backbone of Blue Cross Plans.

By 1935 there were associations stretching from Minnesota to New Orleans to New Jersey to our own in Cleveland, born June 1934.

Endorsed and given unity by the American Hospital Association, Blue Cross Plans developed and flourished along two successful lines . . . individual payment for possible hospital services through group enrollment and participation of community hospitals in accepting prepayment plan patients.

In 1939 medical societies, impressed by the acceptance of the Blue Cross system, organized Blue Shield Plans along the same lines for prepayment of physician's services.

Today there are 115 Blue Cross and Blue Shield Plans with Plans in every state of the Union plus Jamaica, England and Canada. They serve 112 million people, more than the combined populations of our six largest states or equivalent to the seventh largest nation in the world. Their combined work force of 83,000, aided by a 44,000-mile telecommunications network and a giant computer system processes 283 million claims and pays $40 billion a year in claims.

Now at age 50, Blue Cross and Blue Shield Plans nationwide look forward to new challenges and directions, veering from sickness protection to true health protection by promoting good health and better lifestyles.

Blue Cross of Northeast Ohio, in its 45th year, invites you to join with the Blue Cross and Blue Shield Associations in celebrating 50 years of **Working** for a **HEALTHIER America.**

1929-1979
Commemorating fifty years
Working for a healthier America

Blue Cross. Blue Shield.

PASSPORT *to hospital care*

A symbol that opens hospital doors . . .

The Blue Cross organization, like people, has an identity, a character, an appearance which people carry in their minds and recall whenever they think about or deal with our organization, namely, its color and symbol.

Sally The Student Nurse

1933— our conception of van Steenwyck's original idea

Sally the Student Nurse never quite merchandised.

And so the first Blue Cross symbol for promotion and identification was discarded.

That was in 1933 when the St. Paul, Minn. Plan, the first so-called Blue Cross Plan, wanted to switch its advertising from radio to print media. E. A. van Steenwyck, the Plan's first salaried employee, realized the need to have a marketing symbol to identify his product. He first hit on Sally the Student Nurse; she wore a blue and white uniform, the colors of the traditional hospitals' emblem, the Geneva or Greek Cross.

1955—Our ad campaign proclaims the Blue Cross symbol's universal acceptance. Locally, enrollment topped 1 million subscribers.

Van Steenwyck decided that Sally did not have the kind of long-term currency for on-the-spot identity; what was needed was something that didn't change over a long period of time and that would hold the public interest.

1934— van Steenwyck's Blue Cross poster

He hired an artist. This time there was a nurse, but with a difference. Shown only was her sleeve with an armband depicting the symmetrical Greek Cross in solid blue reaching toward the patient. This famous illustration is reproduced on our cover. The advertisement worked. Soon the St. Paul Plan became known as the Blue Cross Plan; other Plans around the country began requesting use of the cross of solid blue.

In 1934 van Steenwyck submitted the cross to the American Hospital Association, which was studying group hospitalization, for approval. Within a year AHA established the Approval Program to sponsor qualified hospital service associations and officially adopted the symbol with the AHA seal superimposed on it. Use of the symbol and words was patented and controlled by the AHA trustees and granted only to local nonprofit hospital service associations which met AHA guidelines.

1941— the AHA adds its seal

Over the next few decades, the Blue Cross system gradually broadened its basic concept from hospital care to health care in other settings — laboratories, health maintenance organizations, clinics. The AHA recognized the system's growth in size and scope. For those reasons, it turned over the ownership of the Blue Cross name and symbol to the Blue Cross Association in 1972. However, the AHA kept its seal.

1972— New emblem, new ownership

A new insignia was designed for the center of the cross — a human figure whose outstretched arms and legs were indicative of a vigorous and healthy mankind. It represented people — not institutions — because better health care protection for people was now the primary concern of Blue Cross Plans.

But most important, despite the change the new Blue Cross symbol still continues to be one of the world's most instantly recognized and readily accepted signs.

WHY SHOULD YOU OR YOUR FAMILY PAY YOUR OWN HOSPITAL BILLS?

or . . . .
The beginnings of Cleveland Hospital Service Association and the "new era" in medicine

by Fraser Kent

The launching of Blue Cross of Northeast Ohio coincides with the discovery of sulfonamides and the beginning of the "wonder drug" era. However, that is only one medical milestone of the many we can count in the last 45 years.

Consider these, for example:

1934 • Barbiturates are injected into the vein to provide anesthesia, rather than using an inhaled agent.

1935 • Cortisone, the first of the corticosteroids, is discovered.
• Dr. Claude Beck of Cleveland performs the first operation to relieve angina pectoris (heart pain).
• The continuous-drip method of blood transfusion proves to be a major advance in treating shock.
• Lobes of the brain are removed ("lobotomy") to relieve anxiety and depression; the beginning of psychosurgery.
• An experimental artificial heart is developed by Dr. Alexis Carrel and Col. Charles Lindbergh.

1936 • Sulfonamide is introduced clinically (having been discovered three years earlier) and is first used to treat blood poisoning. This was the first of the sulfa drugs now used to treat diabetes, kidney disease and malaria.

1938 • Hydrocephalus ("water on the brain") is relieved by insertion of a drainage tube.

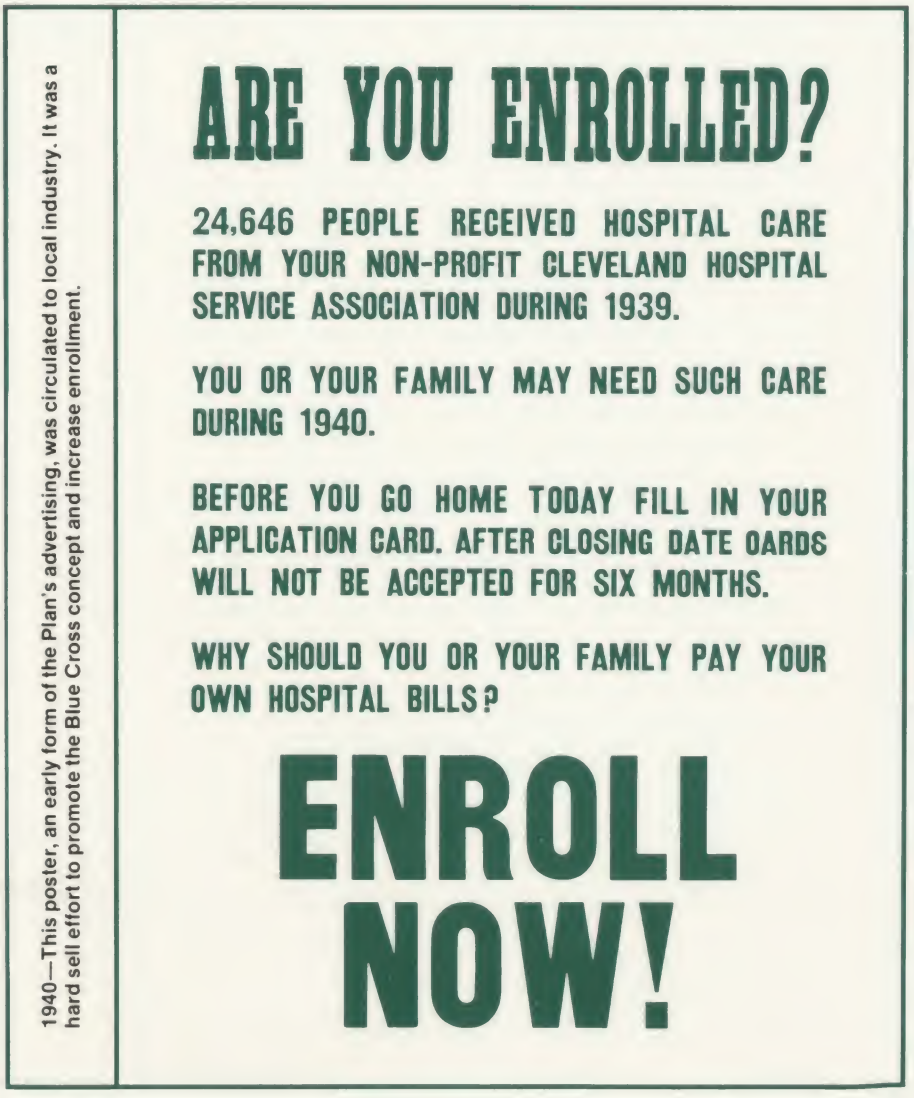
The late 1930s also saw the first explanation of what viruses are and how they work; the first blood banks; the first mass immunizations of children (in this case, for diphtheria) and a yellow fever vaccine.

1941 • Researchers learn how to purify, stabilize and manufacture large quantities of penicillin, which had been discovered in 1928.

1942 • Anesthesia is injected into muscle to relax it; an important advance in abdominal surgery.

1943 • Streptomycin is found effective in treating tuberculosis, especially when combined with other drugs.
• Dr. William Kolff (who later worked at the Cleveland Clinic) invents the artificial kidney in Nazi-occupied Holland, using newly discovered cellophane.

1944 • The nation's first eye bank opens in Brooklyn, N.Y.



1940—This poster, an early form of the Plan's advertising, was circulated to local industry. It was a hard sell effort to promote the Blue Cross concept and increase enrollment.

1945 • The coronary artery is pictured for the first time (aortagraphy), making it possible to see blockages in blood vessels.
• The first effective influenza vaccine is introduced.

1948 • Vitamin B_{12} is isolated, to be used in treating pernicious anemia.
• Introduction of radioimmunoassay, a method of measuring proteins in the blood.

1949 • Dr. Fred Robbins (now dean of CWRU School of Medicine) and Dr. John Enders culture polio virus for the first time, paving the way for polio vaccines. They won the 1954 Nobel Prize for this achievement.
• Cortisone is first used to treat arthritis; the first drug since aspirin to be effective in this disease.

The 1940s also saw the introduction of a tetanus vaccine, antileprosy drugs, and new ways to surgically correct inborn heart defects.

One useful fallout from the 1945 atomic bombs was the development of nuclear medicines, with "cobalt machines" used to treat cancer and radioactive isotopes used to diagnose disease.

1950 • A plastic hip joint is implanted; the first use of the artificial joint replacements.
• The first successful kidney transplant.

1951 • The electron microscope is invented.

1952 • The small bones inside the ear, fused together by disease, are cut free, thus restoring hearing to the deaf.
• The first artificial heart valve is installed.
• Dr. J. S. Geller of Mount Sinai Hospital, Cleveland, separates Siamese twins; these were the first to survive such surgery for at least a year.
• Whole-body cooling ("hypothermia") is introduced.
• The eye's normal lens, damaged by cataract, is replaced with a plastic one inside the eye.
• The advent of amniocentesis (analysis of the fluids surrounding the fetus) provides a way of obtaining genetic information in the unborn baby.
• Ultrasound is developed, using sonar-like waves that bounce harmlessly off internal structures of the body; supplements the X ray in diagnosis.

1953 • The heart-lung machine is invented. Combined with hypothermia during surgery, it opens the way for development of open-heart surgery in the next three years.

1954 • The Salk injectable vaccine against polio is introduced, to be followed in 1960 by the Sabin oral vaccine. Within one decade, these virtually wiped out one of the most dreaded of childhood diseases.
• Dr. Oscar Ratnoff of Cleveland discovers the agent responsible for blood clotting; its absence results in a type of hemophilia. This led to the successful treatment of the "bleeder's disease."

1956 • Cleveland Clinic surgeons stop the heart at will during surgery, without harming the patient.

1958 • Dr. F. Mason Sones Jr. develops a way to take x-ray movies of blood vessels (cinearteriography). This opens the way for still more complex heart surgery.
• The first cardiac pacemaker is implanted to correct irregular heart beats.

1959 • Impramine, the first antidepressive drug, is introduced.

During the 1950s, viruses were first grown in culture; oral drugs for mild diabetes were introduced (to become the center of controversy a few years later); spinal anesthesia was used successfully; discovery of the structure of DNA (the "building blocks" of our genes) is followed by its chemical synthesis.

1960 • Closed-chest massage of the faltering heart is introduced for use by the man-on-the-street in an emergency.

1962 • The advent of microsurgery makes it possible to operate on the minute structures of the eye, ear, blood vessels and nerves.

1936—Clark Restaurant employees learn about the benefits of a "hospital service plan" as CHSA executive M. A. Kelly personally spurs an enrollment drive.

SOME NOTABLE EVENTS

① 1952—First baby born after maternity benefits were added to Blue Cross contracts in 1938 commemorates the occasion of the birth of BCNO's 200,000th baby.

② 1959—BCNO reaches the quarter-century mark.

③ 1957—Cleveland and Akron Plans merge to form Blue Cross of Northeast Ohio, uniting 11 counties under one Plan.

④ 1962—BCNO enthusiastically supported Sabin Oral Sunday.

1963 • A measles vaccine is licensed in the United States.
• The first lung transplant is performed.

1964 • An effective way is found to deal with Rh disease, a blood disorder that kills unborn babies.
• The first successful liver transplant.

1965 • The antigen for serum hepatitis is discovered, leading to the screening of blood donors to prevent transmission of the hepatitis virus during transfusions.

1966 • The first successful heart transplant is performed, drawing more attention than any other organ transplant.
• Chymopapain is injected into damaged discs of the spine, to relieve pain and increase mobility.

1969 • Drs. R. G. Favaloro and Donald Effler of the Cleveland Clinic perform coronary bypass surgery, taking a vein from the leg to bypass clogged arteries of an ailing heart.

The 1960s also saw the introduction of a rubella vaccine; the developing use of plastics to replace missing or damaged body parts; an increasing grasp of immunology; a better understanding of which genes relate to which birth defects; and an increasing use of dialysis (artificial cleansing of the blood).

In the wake of the space program of the 1960s, medicine benefited from moonshot miniaturization, with dozens of devices designed to treat disease and to aid the physically handicapped.

1971 • Massive doses of Vitamin C are recommended for the common cold, reviving an idea first advanced in 1942.

1972 • The acupuncture craze, based on Chinese folk-medicine concepts.

1974 • Ointment and ultraviolet light are combined to treat psoriasis.
• Advances are made in genetic engineering, particularly in combining parts of two genes to form a third "new" gene.

1975 • A hepatitis vaccine is authorized for use in the U.S.

1978 • Birth of the first "test tube baby," created by artificially fertilizing the mother's ovum and, when these began to multiply, implanting them into the womb.

The 1970s brought advances in joint replacement for the knee, ankle and wrist; recognition of "black lung" among coal miners and the importance of sickle cell disease as a threat to American blacks; computerized (CT) scanning of internal organs; clomiprene citrate's introduction as a drug to promote fertility (which also increases the rate of multiple births) and the jogging fad.

Perhaps it is too early for us to grasp the significance of other medical innovations of the 1970s or perhaps Alfred Berger, the chemist, was right in saying that science goes through cycles. In one phase, "fundamental insight is gathered"; in the next, these principles are "applied to potentially practical uses."

Fraser Kent is a widely published author and medical writer. His background includes stints as medical writer for the Miami Herald *and the* Cleveland Plain Dealer.

We're pinching your pennies. Not ours.

or . . . . what does Blue Cross of Northeast Ohio do with the money you pay in?

by Maria Tayek

It was the middle of the Depression. On March 6, 1933 President Franklin D. Roosevelt ordered all federally chartered banks closed. People were left penniless — their cash savings sitting behind locked bank doors.

Not only were average citizens left devastated by the Great Depression, but state and county governments were left with empty pockets as well.

Cuyahoga County, for example, in caring for the hospitalized indigent, was forced to pay the hospitals in scrip — bills printed the size of dollars. In effect they were IOU's. Hospitals weren't the only ones paid in scrip. In 1934 the first Cleveland Hospital Service Association (CHSA) year-end balance sheet showed $365 received in scrip.(CHSA, incidentally, was the former name for Blue Cross of Northeast Ohio.

CHSA sold this scrip to property owners. They, in turn, used the scrip to pay their property taxes to the County. It was, as they say, revolving credit.

Today the balance sheet is much more complicated; the columns and figures have grown substantially. For instance, in 1934, CHSA earned $27,775 in income from sales of ward and semiprivate contracts. Today, fiscal records show the 1978 earned income from subscribers was $363 million.

The past and the present may vary substantially in the amount of income and outflow, but a very basic economic practice remains — the budget.

How does BCNO disperse its income?

1973—Cost containment was stressed in all advertising during 1973-74. This ad particularly expresses our cost-saving efforts.


We're pinching your pennies. Not ours.

All the money we have belongs to you.
But we watch over it as carefully as if it were our own.
And one of the most effective ways we do it is through our Hospital Audit Procedure.
In a nutshell, here's how it works: Each of our member hospitals submits detailed statements showing its actual operating costs, by departments. And if they're covered, we pay them. Otherwise, we don't. As a further check, our auditors examine the hospital books on-the-scene to verify the data they give us.
Last year alone, we saved our subscribers a lot of hard earned dollars through our Hospital Audit Procedure. And this is just one of the many ways we're helping contain hospital costs for our subscribers.
For helping contain hospital costs helps us contain the cost of your health coverage.
Blue Cross® and Blue Shield.® We do more for you. And we do it better.

Blue Cross of Northeast Ohio
Medical Mutual of Cleveland, Inc.
Ohio Medical Indemnity, Inc.

A good example is your own family budget. If you follow a budget, on paydays you divide your check in basically three parts — one part goes to pay for shelter and utilities; another goes to food, clothing and entertainment; the reserve is placed in a savings program.

Blue Cross of Northeast Ohio divides its revenue in much the same manner . . .

One, we use our income to pay for subscribers' benefits.

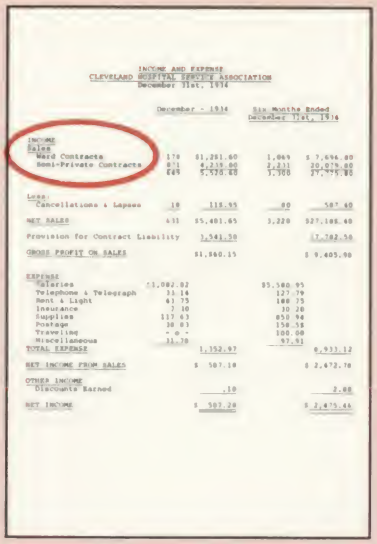
Two, we cover operating and administrative costs of running the Plan.

Three, we set aside "reserves" for future claims. Liken these to rainy day money.

Never in 45 years has the Plan diverted from its philosophy to return as much as possible to subscribers.

In 45 years of service, BCNO has taken in $3.7 billion and spent $3.453 billion of that amount for the coverage of 7,043,000 total cases.

Yet during this time we have not changed our spending habits. We are still " pinching your pennies." And pinch we will as the total health care field becomes more and more involved in controlling costs.



INCOME AND EXPENSE
CLEVELAND HOSPITAL SERVICE ASSOCIATION
December 31st, 1934

	December - 1934		Six Months Ended December 31st, 1934	
INCOME				
Sales				
Ward Contracts	178	$1,281.60	1,069	$ 7,696.80
Semi-Private Contracts	801	4,219.80	2,231	20,079.00
	849	5,501.40	3,300	27,775.80
Less:				
Cancellations & Lapses	18	118.95	80	587.40
NET SALES	831	$5,401.65	3,220	$27,188.40
Provision for Contract Liability		1,541.50		17,782.56
GROSS PROFIT ON SALES		$1,860.15		$ 9,405.90
EXPENSE				
Salaries	$1,082.82		$5,580.95	
Telephone & Telegraph	31.14		127.79	
Rent & Light	61.75		168.75	
Insurance	7.10		30.20	
Supplies	117.63		650.94	
Postage	38.83		156.55	
Traveling	- 0 -		100.00	
Miscellaneous	11.70		97.51	
TOTAL EXPENSE		1,352.97		6,933.12
NET INCOME FROM SALES		$ 507.18		$ 2,472.78
OTHER INCOME				
Discounts Earned		.10		2.88
NET INCOME		$ 507.28		$ 2,475.66

First balance sheet—1934. Note preference for semiprivate rooms. Even then the public was willing to pay more for personalized care.

In 1934 subscribers were paying 60¢ per month for health care which included 21 days of hospital care, meals, routine laboratory services, use of the operating room, X rays, anesthesia and ordinary drugs. Today, with modern technology that same plan would cost approximately $50 per month.

Hospital care in 1934 also only cost $6 to $8 per day. Today's costs have topped $200 per day. Costs have increased as the rate of inflation spiraled following World War II. And although our revenue has increased, so too, have the responsibilities of maintaining the most up-to-date benefit packages.

Today, for instance, the standard BCNO offer to groups is the High Level Benefit contract providing 365 days of inpatient care, $250,000 Major Medical coverage plus diagnostic outpatient care and laboratory.

Yet recently, one heart and emphysema patient with just basic coverage paid only $229 out of the $43,724 it cost for that person's hospital bill.

During the past 45 years a significant number of benefits have been added. Our increased revenue has helped us to better meet the needs of our subscribers. For instance:

CLEVELAND HOSPITAL SERVICE ASSOCIATION

BULLETIN

Thousands of Cleveland workers and their families are being transferred each day to the new

FULL FAMILY HOSPITAL SERVICE PLAN

Employed subscribers now enrolled must fill out a transfer card in order to include all members of their families in their new certificate. Be sure you list the name of each member of your family together with the year of birth.

Monthly Rates

	Ward Service	Semi-private Service
Single Subscriber	60c	75c
Man and Wife	$1.20	$1.50
Man, Wife and All Children from 1 to 19 years	$1.50	$1.90

If you have not as yet enrolled you may add your name and members of your family to the list of your fellow employes during this transfer period without any waiting period.

Ask your employer for your transfer card or new enrollment card.

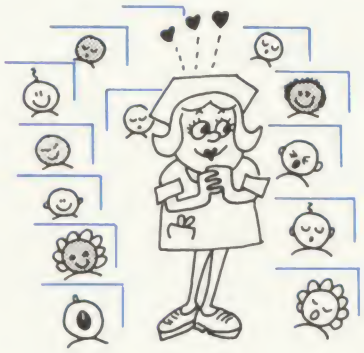
Fill out this card and turn it over to your employer or drop in bulletin board box on or before

PLEASE POST

The late 30's—the *BULLETIN* was a popular advertising mechanism as a sales pitch to industry.

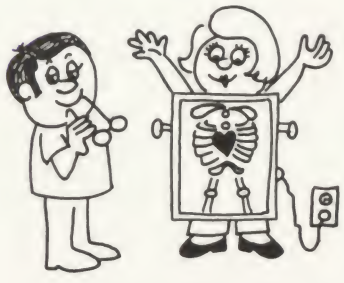
Sales campaigns also went public . . . Cleveland Trust Bank at Euclid & 9th was a favorite promotional spot.

- In 40 years time, BCNO has paid the bill for 954,277 babies. That's more than the total population of Cleveland today.



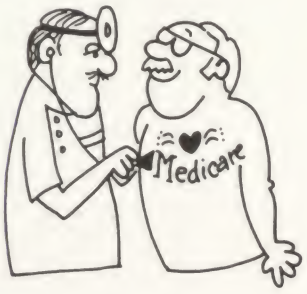
- BCNO has served a total of 6,996,661 inpatients.

- In the area of outpatient coverage in 1970 alone, 57,000 diagnostic tests were covered by the Plan. In 1978 those figures more than doubled.



- In 1969, 50,987 prescription drug claims were paid. In 1978 BCNO claims totalled 1,703,247.

- As a federal government intermediary, BCNO has since July 1966 covered 961,611 Medicare cases.



Altogether the Plan returns 95¢ of each dollar for benefits. The remaining 5¢ is used for revenue, operations and reserves.

The reserve funds are, as we described them earlier, rainy day money.

There is no way of knowing the exact amount of benefits which may be required tomorrow or the next month. Yet, bound by contract, we must pay these services. In order to meet these contract responsibilities we need to set aside enough in reserves to pay future unknown claims.

Total reserves in 1934 amounted to $15,678. Today's figure — $49,881,537.36 — equal to 1.66 months of claims and administrative expense, shows us how costs and benefit responsibilities have indeed changed in 45 years. Today, the 1934 figure would not even cover a major claim such as open heart surgery.

BCNO has come a long way since 1934 when total revenue for the year was approximately $30,000.

Today, health care is a multi-billion dollar business. Yet the bulk of revenue from subscribers is still used for that first and most important purpose of paying benefit services for the Plan's nearly 1.8 million subscribers.

Maria Tayek is a writer/editor for Blue Cross of Northeast Ohio.

Benefits

When is 9 more th

by Joa

What attracts the 1.8 million subscribers enrolled in Blue Cross of Northeast Ohio?

In a word — benefits.

Throughout its 45-year history, the health care packages offered by BCNO have become as sophisticated as the times we live in. As the nation's health protection needs have expanded since the days of the original contract offered by Cleveland Hospital Service Association (forerunner to BCNO) in 1934, so have BCNO's health care coverages advanced. Some of these expanded coverages include contemporary benefit programs — preadmission testing, outpatient diagnostic services, rehabilitation services, psoriasis day care, hemophilia home infusion, prescription drug services, renal dialysis treatment and many other timely health care services.

BCNO benefit programs are designed not only to make adjustments to constantly changing customer needs, but also to exclude the costs of unnecessary services to make more efficient use of health care dollars. By returning more subscriber money through this cost-saving effort, BCNO can offer subscribers less expensive contracts with more benefits.

Some current benefit packages promote cost savings by using less expensive settings to receive the same high-quality health care services. This cost containment effort has resulted in increased emphasis on outpatient benefit programs. Nearly 80% of all nongroup and more than 90% of group subscribers have outpatient benefits. By the end of the year **all** locally enrolled subscribers will have these benefits.

It's "service benefits", incidentally, not "fixed-dollar benefits" that BCNO offers subscribers. In most cases, a patient's hospital care is paid in full. More and more commercial carriers are adopting this approach which pays back benefits in services rather than in fixed-dollar amounts. The difference is that BCNO pays audited costs while commercials must pay charges.

The shift in benefit programs since 1934 when the original prepaid health care concept was introduced by CHSA and today's health care packages is extraordinary.

The original CHSA health care single subscriber plan which covered 21 days of hospital care at a monthly subscription rate of 60¢ per month was introduced during the Depression Era. It was a period of destitution and impoverishment for Northeast Ohioans, for whom sudden illness or injury could prove catastrophic financially.

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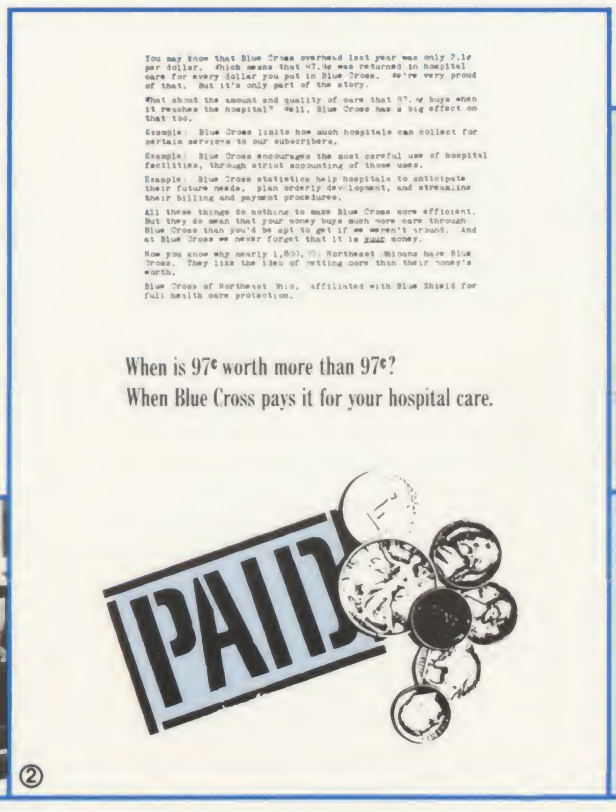
You may know that Blue Cross overhead last year was only 7.1¢ per dollar. Which means that 97.9¢ was returned in hospital care for every dollar you put in Blue Cross. We're very proud of that. But it's only part of the story.

What about the amount and quality of care that 97.9¢ buys when it reaches the hospital? Well, Blue Cross has a big effect on that too.

Example: Blue Cross limits how much hospitals can collect for certain services to our subscribers.

Example: Blue Cross encourages the most careful use of hospital facilities, through strict accounting of those uses.

Example: Blue Cross statistics help hospitals to anticipate their future needs, plan orderly development, and streamline their billing and payment procedures.

All these things do nothing to make Blue Cross more efficient. But they do mean that your money buys much more care through Blue Cross than you'd be apt to get if we weren't around. And at Blue Cross we never forget that it is your money.

Now you know why nearly 1,650,[illegible] Northeast Ohioans have Blue Cross. They like the idea of getting more than their money's worth.

Blue Cross of Northeast Ohio. Affiliated with Blue Shield for full health care protection.

When is 97¢ worth more than 97¢?
When Blue Cross pays it for your hospital care.

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① 1974—Ads on Cleveland buses w as BCNO found a new marketing veh

② 1964—This was one in a series of the value of our low overhead.

③ 1934—The Plan's founders also s early advertising drives.

④ 1937—Cleveland's Mayor Harold enrolls . . . a feather in the cap for CH

at work

97¢ worth an 97¢?

n Savoy

From the date of its inception, CHSA grew at a dazzling rate. During the precarious days of the Depression, people were eager to budget health care expenses along with those of rent and food to ensure hospital care.

By the end of 1934, the initial enrollment totaled 3,200 subscribers. By 1938, it had reached 116,974.

In many ways 1938 was a record-making year for CHSA. A monumental gain in the health care industry was fostered by CHSA when it decided to cover maternity care. CHSA's decision to provide coverage for the "previously noninsurable" maternity care, (since the need for hospitalization is determined months in advance), astounded the conservative element of the insurance industry.

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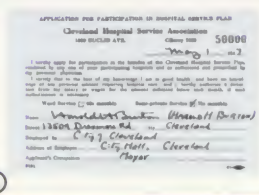

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This was also the year that the unique Blue Cross reimbursement formula for hospital payment was initiated. Under this cost-saving reimbursement formula each member hospital established a per diem, or average daily rate, which the Blue Cross Plan pays for its subscribers. Participating hospitals are reimbursed for the costs of covered services rather than hospitals' actual charges for these services. This formula helps to control inflationary health care costs.

A tremendous boost in CHSA enrollment in 1938 was spurred when special legislation was passed by the Ohio Legislature authorizing CHSA privileges to enroll subscribers in Ashtabula, Geauga, Lake, and Lorain Counties in addition to Cuyahoga County.

It was during this time period that family coverage under the Full Family Hospital Service Plan and sponsored dependents coverage was added.

During the war years, CHSA's benefit coverage and enrollment continued to grow by leaps and bounds.

Full coverage hospital care was increased from 21 to 30 days and partial coverage was provided from the 31st to 120th day. Infants were also covered beginning 30 days from birth. Complete laboratory services and administration of transfusions were now part of the health care plan.

Enrollment soared when federal law held that employer payments for hospital and medical bills were exempt from the war's wage ceiling. As a result, health care coverage suddenly became a popular enticement offered by employers to recruit workers in a tight labor market.

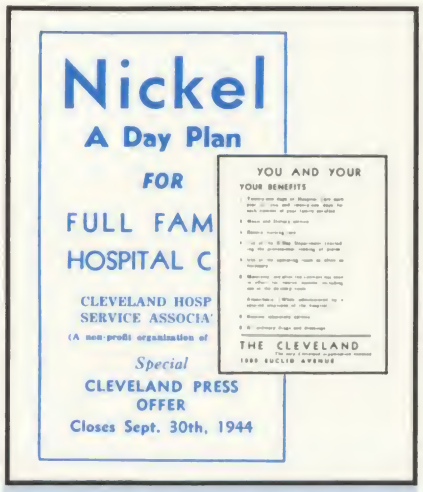
In 1944 the Plan in cooperation with the *Cleveland Press* made a landmark decision to initiate open enrollment to persons who were not in a group. The Plan's individual enrollment model was adopted by other Plans nationwide.

By 1946, enrollment had climbed to 900,000 subscribers which represented well over half the population in the five Northeast Ohio counties in the CHSA service area.

Three years later, CHSA health care coverage was further augmented by 15 new in-patient benefits. Hospital care insurance was used more than any other insurance because it covered the most common and heavy unexpected health expenses.

Among these new benefits were complete laboratory services, transfusions, physical therapy, electrocardiograms, complete pathological examinations, electroencephalograms and formulary drugs.

Unique services such as care of newborn babies for their hospital stay plus tuberculosis and mental cases in private hospitals were added.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Closes Sept. 30th, 1944
YOU AND YOUR
YOUR BENEFITS
THE CLEVELAND

1944—For 5¢ a day, a family had these liberal Blue Cross benefits.

Full hospital care coverage increased to 120 days and CHSA increased payments for bills in nonmember hospitals. Emergency accident outpatient care was inaugurated in 1951 and outpatient operating room service in 1953.

BCNO was steadily gaining the reputation as a forerunner in the insurance industry in controlling health care expenses while simultaneously increasing coverage. This reputation gained added impetus in 1959 when BCNO introduced the broadest hospital and medical/surgical contract to date, the 730-Day Extended Benefit contract. This contract offered two complete years of hospital coverage.

BCNO took another giant step forward in health care protection in 1966 when the Plan was named a Part A Intermediary (hospital and skilled nursing care) for the federal government's Medicare program. As an intermediary, the Plan performed multiple tasks for the health program involving persons 65 years of age and older. These tasks included claims processing, utilization review, audit and other various financial activities associated with Medicare's provision of institutional benefits. Hospital care costs were the principal portions of these and extended care facilities, such as qualified nursing homes and health agencies.

In its role as Intermediary Part A, BCNO paid $257 million to hospitals, skilled nursing facilities, home health agencies, physical therapy agencies and one free-standing renal dialysis center in 1978.

The Plan's Medicare operations were reported well above average by the Social Security Administration in 1975 and are still highly regarded today as one of the most efficient in the country.

It was in the 60's that the Plan extended coverage for prescription drug service, handicapped children and mental care in special hospitals.

The Coordination of Benefits program was instituted in 1968 as a determent against the Plan duplicating payments for benefits covered by multiple insurance companies. By eliminating duplicate payments for health care costs, more equitable and efficient use was made of subscriber health care dollars. BCNO saved nearly $7 million under the Coordination of Benefits program in 1978.

Under the Subrogation contract provision, adopted in 1970, the Plan is able to reclaim payments stemming from accidents for which a third party is liable. This provision saved BCNO $107,294 in 1978.

Not only was BCNO making significant savings by utilizing these conscientious cost containment measures, but the Plan was continually increasing health care benefits.

In the 70's, BCNO extended coverage to include single person maternity care, alcoholism treatment and mental care at state institutions.

In fact, during this decade BCNO developed, introduced or expanded many benefit packages designed to encourage outpatient programs and services as alternatives to the more expensive and perhaps traditional inpatient care.

Preadmission testing, ambulatory surgery, psychiatric outpatient services, psychiatric day care, outpatient diagnostic services, coordinated home health care programs plus a health maintenance organization now form a vital part of BCNO's total benefit structure.

And as the Plan prepares to enter the 1980's it remains determined and committed to provide the best benefits necessary to assure quality care at the lowest possible cost.

It is a commitment that was born 45 years ago.

Joan Savoy is a writer/editor for Blue Cross of Northeast Ohio.

Growing pains

1979—More Than Just An Insurance Company is BCNO's 1979-80 ad campaign theme. It reflects the Plan's expanding role to meet health care needs of the future.

by Patricia Carey

"We didn't know it couldn't be done. We weren't insurance men and didn't know of the conventional wisdom," John R. Mannix, the man credited with the idea which became Blue Cross of Northeast Ohio, is prone to say today.

Mannix bet a straw hat that the fledgling Cleveland Hospital Service Association would have 10,000 subscribers five years after it opened its two-man office in the 1900 Euclid Building in June of 1934. Only 10 months later he got his hat!

Born in the depression years when the odds for survival, not to mention success, were as unfavorable as the prevailing economic climate, CHSA soon chalked up an impressive record on many fronts.

Less than a month after the one-room office opened, the first contract outside the hospital community was signed by Harris Creech, president of Cleveland Trust Co. As his employees followed suit, Cleveland Trust became CHSA's pioneer group.

By the end of the year more than 3,000 persons had enrolled; the number leaped to 18,473 the following year, then to 42,500 in 1936. By 1938, nearly 117,000 people were convinced that the voluntary association for prepayment of hospital services was a good idea.

The operation was simple in the early years. A team of two men would make an appointment to describe the plan to a group of employees. While one talked, the other handed out application cards which asked name, address and little else. Additional notations were made on the applications as the two returned to the office via streetcar. Each card was personally signed by Director John A. McNamara, the Plan's first chief executive.

Sixteen hospitals participated in the Plan in those days, all of them in Cuyahoga County. Today, Blue Cross of Northeast Ohio, as it became known following the Association's merger in 1957 with the Akron Hospital Service, serves and protects nearly 1.8 million subscribers in 11 counties and is associated with 58 member hospitals.

Indeed, it has been a long, hard road since that day in 1934 when a committee of dedicated Clevelanders obtained a $7,500 loan from the Welfare Foundation to finance its health care venture. The loan was repaid in six months and since then, BCNO has paid $3.453 billion in hospital bills.

While some figures have increased astronomically, at least one has dropped dramatically since the early years.

Even after some of the start-up costs were paid off in 1937, 13% of the Plan's income went toward operating expenses. Today more than 95¢ of every subscriber dollar is returned in benefits.

It's tempting, as we observe some of the artifacts of a Blue Cross Plan in the late 70's — computer addressed letters, a massive and complex communications system, every person and every benefit seemingly a number — to think that things have changed a lot since the beginnings of BCNO.

Yet a look at early CHSA promotional pieces reveals concern about rising hospital costs, the wisdom of government health programs and keeping budgets lean. Some of those concerns were expressed as early as 1937.

What is BCNO today? Still a not-for-profit, prepaid health plan — but with 1.8 million

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subscribers, more than a thousand employees, computer technology which staggers the mind, 60,000 phone calls and 7,000 letters a month, $344 million in paid claims this year.

For many years after 1934 the business of a Blue Cross Plan was to serve subscribers and the hospitals which provided health care to them. As revolutionary an idea as it was then, it offered benefits and not much more.

Today, in the Plan's 45th year, it still provides benefits, of course. But as the problems of health care have grown more complex, so has BCNO.

Like CHSA in the early years, BCNO continues to look for a better way to meet the health needs of today . . . affordable, quality health care available to all . . . not just treating the ill, but teaching people how to live healthy lives . . . reasoned approaches to the unique problems of advancing technology . . . creative, new ways to deliver ever-expanding health services.

For instance, its relationship to hospitals has changed dramatically.

Relationship to Providers of Hospital Care

In the beginning, Cleveland's Blue Cross Plan was an association of hospitals which accepted members who wanted to prepay for their care in those hospitals. It was an association designed to help both members and the hospitals stay afloat during the trying Depression years.

1941—Bleak by today's standards . . . this was the Plan's first computer center. Offices were located at 1900 Euclid Building.

The Plan has been interested in keeping hospital costs down since the beginning. Urgent concern was expressed after World War II when the CHSA Annual Report cited a 165% increase in the Plan's per diem payments to hospitals between 1934 and 1938, and **another** 116% increase between prewar 1940 and 1948.

As seriously as the problem was viewed then, never before has so much of the Plan's energy and resources been directed at keeping costs down. Today a whole complement of BCNO's staff, assisted by computer technology, is devoted to this task.

Armed with data collected about thousands of hospital operations in its 11-county area, BCNO helps individual hospitals pinpoint and correct cost "leaks"

Its role as a central clearinghouse of information does more than eliminate duplication of effort and save money. It also improves the quality of the care you receive.

1941—Plan marks 1 million days of care for subscribers. Poster display appears at 9th & Euclid.

Committees of medical professionals review diagnoses, treatment and length of stay in light of the accepted practices revealed by our data. You receive the best of care — no more and no less than necessary. Even though you are not a Blue Cross subscriber, when you check into a participating hospital, you benefit from the information we compile.

Sometimes just having the information available isn't enough to spur cost-saving changes. More substantial encouragement is needed. That's where Blue Cross Plans are in a unique position with hospitals.

The announcement we made recently on routine admission tests (those not ordered by a physician) is a case in point. Most of our member hospitals **already** avoid giving "routine" tests to all patients. And we applaud their good judgment. But in other cases, it's easy to see how our decision to refuse automatic reimbursement might affect hospitals which continue to give "automatic" tests.

Similarly, we insist that hospitals use generally accepted, sound business practices before we'll agree to reimburse them for costs. We ask a lot of questions and do a lot of checking:

- Have they sought competitive interest rates on loans?
- Do they have effective bad-debt procedures?
- Are they purchasing supplies at the lowest possible prices?

1978—One of the many community health events BCNO sponsors is the *Health Run Spectacular.*

We do the same before paying a claim:

- Is the service covered in the patient's contract?
- Was it ordered by a physician? Was it actually performed?
- Does the procedure make sense in light of the diagnosis?

And finally, we refuse to reimburse a hospital for costs related to building expansion or expensive equipment that the government's local health planning system, the Metropolitan Health Planning Corporation, has deemed unnecessary.

All of those changes place us in a delicate relationship with hospitals. We want to — and **need** to — cooperate in order to provide the best possible service to you, the subscriber. But it's also up to us to keep an eye on hospital costs.

Relationship to Subscribers

The president of a Cleveland company wrote John McNamara a letter typical of the thousands we have received since the early 30's.

"Less than a year ago, when I started my Hospital Service, little did I realize that I would ever come close to spending twenty-one days in the hospital," he wrote. "I really feel that you did the Company, as well as myself, a big favor in allowing us to join your Association."

Today's letters don't often thank us for the "favor" of joining, but our first responsibility to subscribers remains health care benefits. Today, though, our total responsibility to you, the consumer of health care, is much broader than that.

Our public education programs are designed to let you know how you can help keep health care costs down and to encourage healthier lifestyles, the ultimate cost-saver.

We have invested a lot of time and energy in such programs as the Health Fairs, for example, because we believe early detection of a problem like hypertension will pay off in less costly treatment.

Booklets and folders guide subscribers in using less costly outpatient testing, ambulatory surgery, our Euclid-Mentor Regional Health Plan, and other alternative health care delivery systems designed to provide quality care more economically.

Relationship to Government

Blue Cross Plans are not like commercial insurers. We make no profit, for one thing. And instead of guaranteeing an amount of money, we guarantee a level of service.

All of this means we are regulated and run differently than commercial insurers:

- Our nongroup rates must be approved by the Ohio Department of Insurance.
- We reimburse hospitals for services they provide you, our subscribers.
- Many areas of our operation are mandated by law or Insurance Department rules.

Even though we do not deliver health care services — hospitals, clinics, health maintenance organizations and others do that — we are held responsible for **their** cost containment efforts, too. Certainly, we have an impact, but the fact remains that we have no real authority to enforce cost-saving changes upon providers.

And, of course, regulation of this sort has had a hand in changing our relationships with providers and subscribers. How will these relationships change over the next several years? We don't know. We **do** know they will continue to change.

We remain firm in our conviction that only through the cooperation of you, our subscribers, and providers can we hope to slow the rise of costs, improve health care and enjoy longer, healthier, more satisfying lives.

Patricia Carey is a writer/editor for Blue Cross of Northeast Ohio.

1929-1979
Commemorating fifty years
Working for a healthier America
Blue Cross
Blue Shield

OUR GOAL . . . . Better health through

Any projection of the future of health care in America must begin with recognition of Blue Cross as one of the most potent economic participants in the system.

It wasn't really meant to be that way. The whole idea behind what became Blue Cross was a plan modestly developed by a few hospital and social welfare people to relieve the sick and injured of financial hardship at the time of hospitalization. In altogether too many cases 45 years ago not even the mortally ill could afford the going rate of $5 a day for hospital care.

by F. Gordon Davis

So Blue Cross pioneers did what actuarial experts had claimed couldn't be done. They offered certain needed hospital services prepaid, and the cost at the time was only 60 to 75 cents a month per subscriber.

Blue Cross broke the trail for a health care prepayment industry so big that today it suffers from the common dilemma of enterprises of size, however beneficial they may be. Few people understand its workings. Most simply see a lot of money being allocated to health protection — a quite important slice of the family budget — and they cannot help but wonder whether that amount is truly necessary. They raise questions about the operations not only of prepayment programs but of the institutions and professions that provide health services.

All this may be another manifestation of what has been called the Age of Consumerism, but it is nonetheless critical in implications for the future. America is still essentially a democracy. What the people want most is basically what they get, and their choices in health care and its financing are still unresolved.

One long-established social guideline, for example, has to do with the nonprofit charter of many of our most dedicated service structures. Blue Cross and its member hospitals were established as nonprofit, public service organizations, and they have never departed from this role. To express it in simple terms, neither Blue Cross nor the hospitals "make money". There are no shareholders to profit through dividends or other means; the governing boards are composed of unpaid volunteers from their respective communities.

A second guiding principle in health care is that of individual freedom. Americans are


Better health through better care

25 years of Blue Cross Progress promises ever increasing health security to you and yours

Blue Cross of Northeast Ohio

SPONSORED BY THESE NON-PROFIT HOSPITALS

1959—This newspaper advertisement was part of an announcement observing Blue Cross of Northeast Ohio's 25th anniversary. The *Better Health* theme is still today's goal.

better health care

still free to choose between methods of payment for health services, between hospitals and doctors and other providers. In most of the rest of the world this freedom is either nonexistent or so limited in options as to be more wishful than actual.

A third and heavily issue-ridden principle involves health economics. There is much talk of free health care for everyone, which is of course a delusion. The bill must be paid, whether by individual purchasers, groups or the taxpayers. Much of the sentiment for national health insurance seems to be based on the idea that somehow it would cost the average person or family less — another delusion. That has not been the experience of any country with nationalized health care. Elsewhere throughout the world wherever advanced care is available, costs have risen as they have in the United States.

Still, the upward trend has been disturbing and people tend to forget that what they buy in health services today is but dimly related to what was available when Blue Cross began. Today's health services are as little like those of 1934 as the modern automobile is like the horseless carriage.

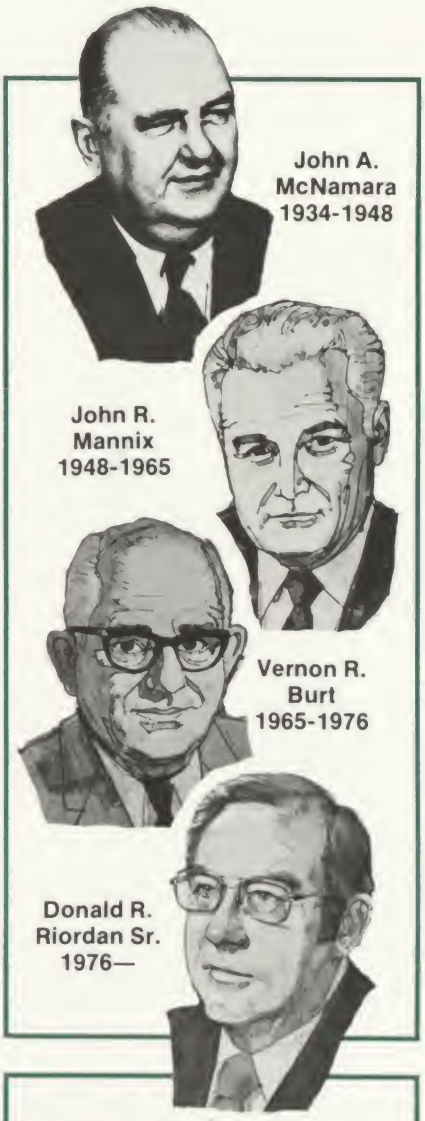
Millions of Americans are living today who could not have survived with the limited medical resources available to them in the 1930's. Most of the happy survivors know this even though they have not estimated what it has cost to save their lives.

This — the development of comprehensive and often extremely intricate health care services — is one reason why costs have risen. Another is inflation, with today's dollar worth less than one fifth of its market value in the 30's.

Finally, the cost of human effort has risen dramatically and the increasing complexity of health care services demands more of this effort at much higher levels of skill. There have been drastic increases in the numbers of hospital employees required to serve the same number of patients, and equally drastic requirements in the educations they must obtain and the skills they must develop.

It is not that savings to help counter rising costs are impossible. Savings already have come about voluntarily and through the years to an extent seldom appreciated by most observers. The facts and figures are readily available to all who will examine them. But it is wishful thinking to expect that, under any form of administration, further savings can in any way be great enough to offset the consequences of continuing inflation, popular demand for greater medical benefits, and rising standards of living for the American people.

On the contrary, to stay below proposed new costs ceilings, hospitals and health professionals will have no choice but



STRONG LEADERSHIP LINKS PAST TO FUTURE

Four presidents have guided Cleveland's Blue Cross Plan in its 45-year span. Their individual talents have contributed greatly to the organization's growth and achievements:

John A. McNamara—blazed the way with forceful enrollment campaigns.

John R. Mannix—51 years in the health field; pioneer of Blue Cross concept; headed Cleveland's and two other major Blue Cross Plans; internationally recognized by health care leaders.

Vernon R. Burt—former legal counsel; helped to get state legislation passed in 30's to aid nonprofit hospital service associations; added Medicare to Plan's business.

Donald R. Riordan Sr.—his financial expertise and war on rising health care costs are driving forces in meeting challenges of cost containment.

to place corresponding limitations on certain existing services, perhaps to discontinue some services altogether. The more dramatic and expensive procedures such as heart operations, organ transplants and the salvaging of critically ill newborn infants will probably be the first to suffer.

Despite public pressure on Washington for action in the health care field, it is unlikely that a government monopoly of health services will gain popular support. Freedom of choice, belief in the benefits of competitive methods, and fear of undue concentrations of power are ingrained characteristics of the American attitude.

For their part, responsible leaders in both Congress and the Executive Branch, although committed to the idea of the fullest possible health care protection for all citizens, have had grave fears of what the cost of a major program would do to a government already struggling under a staggering tax and debt load.

Whatever form of national health insurance becomes a reality therefore will lean heavily on the participation of private and local or regional organizations and agencies. Employers will continue to be called upon to handle the expense of coverage for employees and their families. State and local governments will be expected to assist and police the use of existing health care facilities and the planning of new ones. Private "distributors" such as Blue Cross and Blue Shield will assist the collection of revenues and their proper administration in

Lowering the health care price tag . . . as a community service, Blue Cross and Blue Shield in Northeast Ohio began offering *"Take Care of Yourself"* in 1977. This consumer's guide to medical care tells when to use home treatment, when to see a doctor and how to develop good health habits.

the care of beneficiaries. New governmental mechanisms will be established to supervise the whole.

Any assessment of things to come must acknowledge the great increase in federal power and its sometimes overwhelming effect on local affairs. The force already has been largely exercised in drafting the conditions under which the national government will allocate money for state and local projects of many kinds. Federal standards must be met before supportive money is forthcoming.

Typical in the health field are requirements for the establishment of various regional and statewide bodies to pass judgment on hospital expansions and purchases of equipment, the number of beds allowable in local communities or areas, even the appropriateness of medical treatment in individual cases. History confirms that increase in the use of such powers is as certain as the daily ascension of the sun.

Thus, to speak in contemporary terms, there is both good news and bad news in the health care picture of the future. Certainly the American economy as a whole confronts a growing need of measuring capabilities against available resources. As with a family that has extravagantly overspent its means for a long time, the past is catching up and belt-tightening is at hand. The process is certain to affect the health care field not because of poor performance but because, to a considerable extent, the public has not permitted the measurement of services to be provided in terms of dollars.

If the past is indeed prologue to the future, we should note that Blue Cross and Blue Shield were born in the most devastating belt-tightening interlude of this century — the Great Depression of the 1930's. There is no evidence that American ingenuity has diminished since then. Thus, instead of being shackled by new problems and rising restraints, Blue Cross and Blue Shield in common with the American health care system as a whole can be expected to use these challenges as stepping stones to still greater human services.

When all pertinent influences are taken into account, that is a safe prediction.

F. Gordon Davis has served as a science and health writer for papers in Buffalo and Cleveland and as a columnist for a national hospital trade publication. His background includes many years of service as public relations consultant to Blue Cross Plans, hospitals, hospital associations and to health-oriented foundations.

1932 John R. Mannix begins formulating plan of prepaid medical insurance. Forms committee to study feasibility of proposal.

1934 March 30—file articles of incorporation with secretary of state for Cleveland Hospital Service Association.

June 15—hold first official board meeting. Business office opens. CHSA offically in business.

Coverage—each contract designed to cover only 1 person; provides 21 days of inhospital care.

Enroll first group on July 13.

1935 Enroll 10,000th contract holder; a phenomenal rate of growth in less than a year.

Institute family coverage. Previously, only contract holder had full coverage. Now family members receive half of the benefits.

Extend benefits to include meals and general nursing, routine laboratory services, Xrays, operating room, anesthesia plus ordinary drugs and dressings.

1936 Number of subscribers multiplies 14 times.

1938 Initiate reimbursement formula for hospital payment. Actual expense hospital incurs in caring for a patient is basis for payment.

Number of persons required to form a group lowered from 10 to 5. Offer full family contract. Add maternity coverage.

1939 Ohio legislature permits subscriptions from residents in counties adjacent to Cuyahoga County.

1941 500,000th subscriber enrolled; reach 1 million days of care.

"Service" debuts, CHSA's first employee publication.
(It was suspended in 1942 to conserve paper during the war years and resumed in 1946. In 1950 it reappeared as "Cross Section" and has been published continuously since then.)

1943 More than 52% of the population of Ashtabula, Cuyahoga, Geauga, Lake and Lorain Counties subscribe to the Blue Cross Plan.

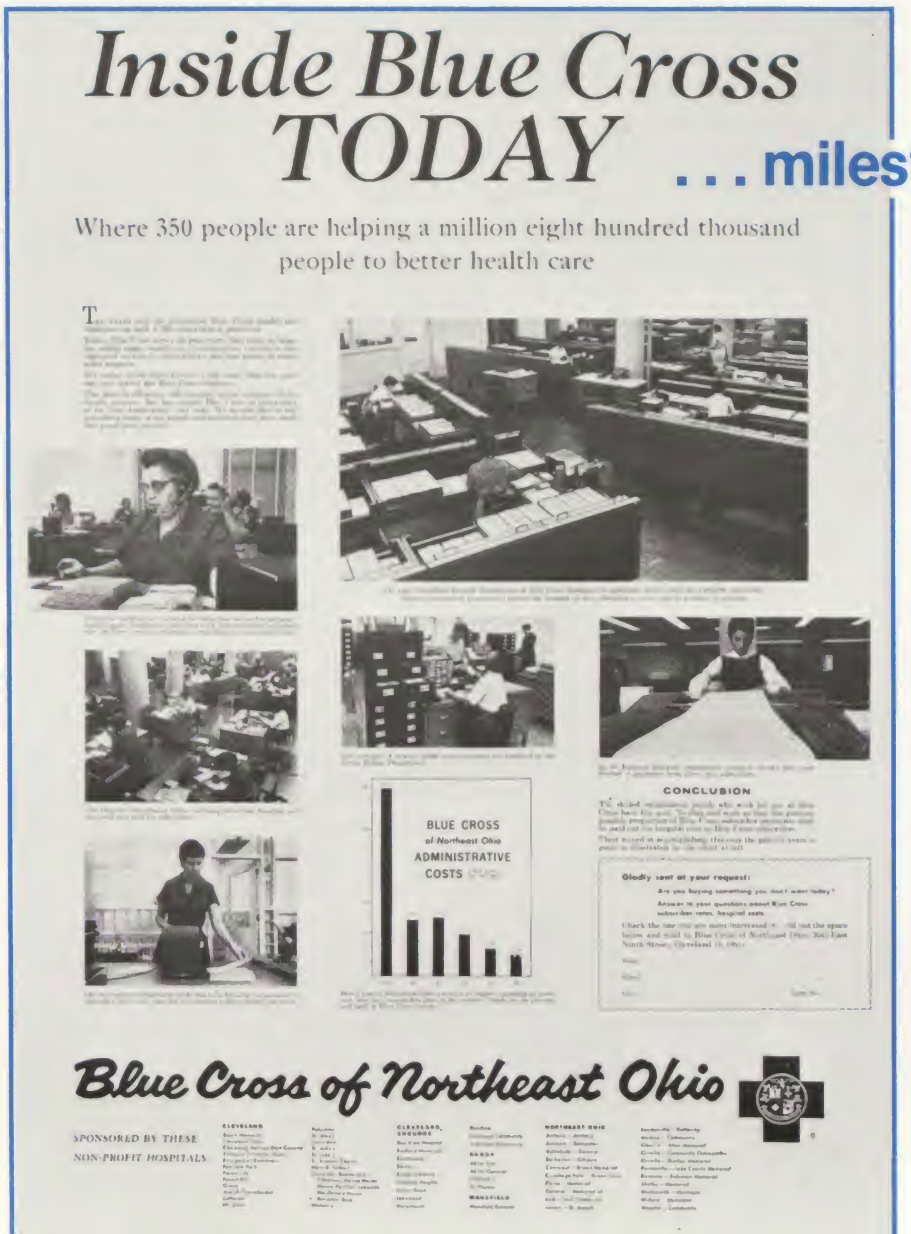
1945 Extend coverage to 30 days.

Add partial coverage from 31st to 120th day.

Form Medical Mutual to offer indemnity for surgical and obstetrical care.

1946 CHSA subscribers now number 900,000.

1959—This advertisement commemorated Blue Cross of Northeast Ohio's 25th anniversary.



. . . milestones in our progress

Four decades and a half of community service as a prepayment health care plan have been marked with accomplishments of such scope that it is nearly impossible to list them all.

Here then are the major highlights depicting the success of the Blue Cross movement in this area.

1947 CHSA moves to the Rose Building.

1949 Inaugurate 15 new benefits including complete laboratory services, transfusions.

Reciprocal agreement for care with the country's other 46 Blue Cross Plans.

1951 Emergency accident care added.

Increase allowance for care in nonmember hospitals.

70 and 120-day full coverage contracts are made available.

Enrollment tops 1 million.

Outpatient services added to contract.

1952 $100 million in hospital bills is paid by CHSA since its inception.

1953 Outpatient operating room service added.

1956 Add outpatient diagnostic benefits.

1957 July 1—CHSA and Akron Hospital Service merge to become Blue Cross of Northeast Ohio.

Total number of persons covered by BCNO is 1,778,509.

1959 Broadest hospital and medical-surgical contract to date is offered—730-day extended benefit program.

1961 Total payment for care to subscribers passes $500 million mark.

1966 Select Blue Cross for Medicare Part A Intermediary; Medical Mutual as Part B Intermediary.

Medicare and BC 65 complementary coverage effective.

"Health Lines" radio series begins.

Add outpatient psychiatric benefits.

1968 New benefits broaden coverage to include handicapped children and full coverage for mental care in special hospitals.

Add Coordination of Benefits.

Inaugurate merit rating principle.

Hold first student enrollment.

1969 Medical Mutual announces dental program.

Prescription drug program becomes effective.

Pool rates for nongroup subscribers are started.

1970 BCNO completes multimillion dollar computer center.

Shared Hospital Computer Program is initiated.

1971 Establish Major Medical coverage.

Formulate plans for the Center for Health Data of Northeast Ohio.

1972 New Blue Cross symbol is adopted.

1973 Offer high-level benefit program and catastrophic protection plan.

Establish first annual John R. Mannix Health Forum.

Add Preadmission Testing benefit to all contracts.

Develop first perspective reimbursement program based on negotiable budget.

1974 Offer continuous open enrollment and low-option/less expensive coverage to nongroup subscribers.

Enrollment reaches 52% population of 11-county service area.

Add outpatient hospital/doctor's office laboratory coverage.

Gear operations towards support of capability to assist the coming of a federal national health insurance program.

1975 Establish Peer Review Data System to assist area providers in review of medical cases.

Join with other Ohio Plans to form statewide sharing of services agency.

Offer hemophilia home treatment program and home health care (posthospital) program.

Outpatient claims outnumber inpatient claims; signals Plan's effort to contain rising health care costs.

Merit rating formula proposed for nongroup subscribers; refused by Ohio Department of Insurance.

Federal government finds Blue Cross Plans No. 1 as fiscal managers for Medicare program.

Establish psoriasis day care program at Cleveland Clinic.

1976 Join with Blue Cross system in calling for health care reforms and patient education programs.

Initiate QUEST Peer Review Program to improve service to area providers in meeting federal and medical care requirements.

Establish Subscriber Grievance/Complaint System to speed up service to subscriber problems.

Begin two-year conversion to plastic ID cards for all subscribers.

1977 Monkeys Lifestyles TV commercial voted best in world by Hollywood Radio & Television Society; wins gold medal at Atlanta Film Festival; appears on Johnny Carson show.

Conduct first consumer cost containment contest campaign for public's suggestions on ways to hold down health care costs.

Offer comprehensive alcoholic treatment benefit package to enrolled groups.

Receive praise in Congressional Record, along with other Ohio Plans, for offering nationally acclaimed medical guide, "Take Care of Yourself", to the public at a discount.

Coverage for psychiatric treatment provided in 3 state-operated mental facilities.

Implement Hospital-Based Physician Adjudication System to alleviate hospital claims handling for staff physicians.

Total benefits paid since inception reaches $3 billion; total Medicare benefits paid since 1966 reach $1 billion.

Coordination of Benefits becomes mandatory for all enrolled groups.

Begin statewide nutrition education program for Ohio's secondary schools.

Hold first CEO luncheon for community leaders on health care cost education.

1978 Emphasis on healthy lifestyles . . . cosponsor first community Health Fair, Health Run Spectacular, national AAU Racewalk Championship and Running Clinics.

Offer first HMO program, the Euclid/Mentor Regional Health Plan with facilities in Euclid and Mentor.

Offer coverage to groups for inpatient psychiatric care and inpatient/outpatient/residential treatment for alcoholism.

Declare "war" on health care costs; aid in the closing of Polyclinic Hospital to reduce area's hospital beds.

Participate with local health planning groups to develop Hospice Program; with industry to form Greater Cleveland Coalition on Health Care Cost Effectiveness.

Record set—public hearings on proposed rate hike runs 8 days.

Cost containment efforts significant—cost of health care in Greater Cleveland less than the national average.

Add postdischarge testing and homelike maternity programs.

BLUE CROSS OF NORTHEAST OHIO

FINANCIAL STATEMENT

Balance Sheet — for the year ended December 31, 1978

Assets:	1978	1977
Cash and Secured Deposits	$ 12,842,513	$ 5,777,808
Investments	89,508,841	65,831,340
Accrued Interest Receivable	1,675,327	1,043,345
Amounts Due From Subscribers	45,225,922	40,359,639
Miscellaneous Accounts Receivable	7,573,081	7,311,493
Fixed Assets — Net	2,614,868	3,202,805
	$159,440,552	$123,526,430
Liabilities and Reserves:		
Incurred Claims Unpaid	$ 53,318,452	$ 36,875,867
Other Accounts Payable	32,279,718	24,400,043
Unearned Income	16,489,102	14,449,162
Liability For Group Rate Credits	7,471,742	2,828,658
Reserves and Unassigned Funds	49,881,538	44,972,700
	$159,440,552	$123,526,430

Statement Of Income And Expense For The Year Ended December 31,1978

Earned Income From Subscribers	$363,408,321	$337,383,511
Other Income	6,787,576	4,122,264
	$370,195,897	$341,505,775
Claims Incurred	$343,665,694	$300,796,850
Administrative Expenses Incurred	16,897,382	16,015,502
	$360,563,076	$316,812,352
Change In Reserves and Unassigned Funds-Operations	$ 9,632,821	$ 24,693,423
Adjustment For: Liability For Group Rate Credits	$ (4,643,084)	$ (1,586,275)
Unrealized Capital Loss	(7,321)	(129,371)
Special Fund Reserve	(73,578)	—0—
Net Change In Reserves and Unassigned Funds	$ 4,908,838	$ 22,977,777

Above figures are filed with the Director of Insurance of the State of Ohio in the annual statement of Blue Cross of Northeast Ohio for the year ended December31, 1978.

This financial statement for 1978 is reproduced here for you as a convenient summary of our fiscal operations. It is also contained in the attached fully detailed 1978 Annual Statement as it appeared in the *Cleveland Plain Dealer* and the *Cleveland Press.*

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Commemorating fifty years
Working for a healthier America

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Blue Cross
of Northeast Ohio

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